STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297104	A. BUILDING _____ B. WING _____	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICE	2721 E. Russell Road Las Vegas, NV 89120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare re-certification survey under 42 CFR Part 484 - Home Health Services, conducted at your agency from March 25, 2009 through March 31, 2009. The active census on the first day of the survey was 56. Fifteen clinical records were reviewed, including four closed records. Five home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	G 000	5-27-09 Acceptable plan of correction with a few minor corrections via telephone w DON/Clinical Director- CEastburga	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by Based on clinical record review and document review, the facility failed to ensure all persons furnishing services maintained liaison in order to effectively coordinate and support the objectives outlined in the plan of care for 10 of 15 patients (#1, 2, 3, 5, 7, 8, 9, 12, 14, 15).	G 143	A. The Agency will immediately improve the liaison between disciplines in order to improve coordination of care to effectively support the plan of care. Disciplines verbally communicate with each other every two (2) weeks and as needed (i.e. change in plan of care). Coordination with the physician is communicated when any changes in the patient's status occurs. All disciplines document this communication in the visit notes in the coordination of care area/box on the clinical notes. Also, each discipline completes a written Case Conference form every two (2) weeks and as necessary. This is submitted to the Clinical Director/QA staff. In addition, coordination of the patient's discharge is communicated to the appropriate disciplines on the final visit as evidenced by documentation on the final visit note. Patients 1,2,5,8,12,14 and 15 have already been discharged. Patients 3, 7, & 9 and all current & future patients will benefit from the improved coordination of care provided by this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Clinical Director — (X6) DATE: 5/9/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 143	Continued From page 1 Findings include: Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin-dependent diabetes mellitus. A skilled nurse (SN) saw Patient #1 a total of 11 times. A physical therapist (PT) saw the patient 14 times. On 7/6/08, the SN documented Patient #1 was "non-compliant - does not use walker at all times has unsteady gait." In the lower left hand corner of the Skilled Nursing Visit Notes (SNVN), was an area for the SN to indicate care coordination had occurred with the physician, PT, occupational therapist (OT), speech therapist (ST) and/or social services (SS). On all SNVNs for Patient #1, the area in the lower left hand corner lacked any documentation indicating SN had coordinated care with PT regarding (non-compliance of patient regarding walker use). On 8/1/08, the PT wrote, "... see D/C (discharge)" just above the signature line of the revisit note for Patient #1. Two lines above "... see D/C", there was an area to document coordination with the physician, SN, OT and/or other. The clinical record lacked documentation indicating PT had notified SN regarding Patient #1's discharge.	G 143	B. The Agency will ensure compliance for all patients through QA monitoring of concurrent documentation of liaison/coordination between all disciplines furnishing services, as well as the physician. In addition, tracking of all written case conference forms will be completed by the Clinical Director. C1. The Agency has scheduled a mandatory in-service on May 8, 2009 for all disciplines on care coordination/liaison and documentation of the coordination. The in-service was presented by the Clinical Director (See Agenda - Attachment A). This in-service instructed disciplines on communication/coordination of care with each other every two (2) weeks and as needed, as well as with the physician, and documentation of this communication will be evident in the clinical notes. Instruction on written case conference forms was included. The Agency plans to present the same mandatory in-service during the week of May 11-15, 2009, with attendance by all disciplines documented. C2. The QA staff will be instructed on monitoring documentation of this communication. C3. A telephone directory of disciplines will be provided to all disciplines and the disciplines will be informed at the start of care, and as the plan of care changes, of the names of other disciplines involved. The disciplines will be directed to the physician's phone number on the Plan of Care. D. Monitoring the corrective action will be accomplished by tracking of written case conference forms by the Clinical Director. In addition the QA staff will monitor the documentation of verbal communication between disciplines, and with physicians on the clinical notes and intervene as necessary. E. The Clinical Director will be responsible for monitoring compliance of this corrective action. The QA staff will assist and report to the clinical director in monitoring the documentation. In addition, the Clinical Director/QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of completion: June 19, 2009	

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G 143	Continued From page 2 Patient #2 The start of care for Patient #2 was 11/11/08. Diagnoses included long term current use of anticoagulants, deep vein thrombosis (DVT) site not specified and chronic pulmonary obstructive disease (COPD). Patient #2 was seen by SN nine times. The patient was seen by PT twice. On 12/11/08, PT discharged Patient #2. The clinical record lacked documentation indicating PT advised SN of the discharge. Patient #3 The start of care for Patient #3 was 3/20/09. Diagnoses included paralysis agitans (Parkinson's disease) and difficulty walking. After the start of care by SN, PT evaluated Patient #3 on 3/24/09. OT evaluated the patient on 3/25/09. The clinical record lacked documentation PT and OT communicated with each other and the SN to coordinate care for Patient #3. Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure (CHF), hypertension, difficulty walking and bladder incontinence. On 12/16/08, PT saw Patient #5 for an evaluation only. The clinical record lacked documentation indicating SN was notified that PT would not be	G 143		

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G 143	Continued From page 3 seeing the patient for additional visits. The occupational therapist (OT) saw Patient #5 six times. The final OT revisit note and the OT discharge summary lacked documentation indicating SN was notified of the OT discharge. Patient #7 The start of care for Patient #7 was 12/18/08. Diagnoses included hypertension, congestive heart failure, insulin-dependent diabetes mellitus, muscle weakness and difficulty walking. PT saw Patient #7 for seven visits and discharged on 3/11/09. The clinical record lacked documentation indicating the physician and SN had been notified of the discharge. Patient #8 The start of care for Patient #8 was 11/12/08. Diagnoses included arthritis, difficulty walking and a history of falls. PT saw Patient #8 for 18 visits and discharged on 1/22/09. The clinical record lacked documentation indicating OT had notified the physician and SN of the discharge. OT saw Patient #8 twice and discharged the patient on 12/31/08. The clinical record lacked documentation indicating OT had notified SN of the discharge. Patient #9 The start of care for Patient #9 was 2/21/09. Diagnoses included pressure ulcer, coronary	G 143		

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G 143	Continued From page 4 artery disease and asthma. The OT completed a missed visit report (MVR) on 3/6/09 indicating Patient #9 went into the hospital (date unknown). The clinical record lacked documentation indicating physician, SN, PT and OT were notified of the patient's status. Patient #12 The start of care for Patient #12 was 1/19/09. Diagnoses included hypertension, chronic pain, difficulty walking and bipolar disease. On 2/19/09, PT discharged Patient #12. The PT revisit note lacked documentation indicating the nurse on the case was notified of the patient's discharge from PT. Patient #14 The start of care for Patient #14 was 2/25/09. Diagnoses included multiple sclerosis, hypertension and coronary disease. The clinical record for Patient #14 lacked documentation indicating SN and PT communicated with each other to coordinate care. Patient #15 The start of care for Patient #15 was 2/24/09. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, hypertension and insulin-dependent diabetes mellitus. On 3/17/09, the PT documented on a revisit note, "patient states she cannot do much exercise	G 143		

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G 143	Continued From page 5 secondary to fear of seizures." The clinical record lacked documentation indicating SN was notified regarding Patient #15's fear of exercise bringing on seizures. Note: The patient was on an anti-seizure medication. The plan of care did not list seizures as a diagnosis. The Agency's policy, "Management of Information" Number 7.20, effective on 6/22/06, stated on page 3 of 4, "...#4. The final visit paperwork will include: A. Visit note for that discipline; include notification of other team members if indicated e.g. CHHA (certified home health aide)..."	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on clinical record review, the facility failed to ensure effective interchange, reporting and coordination of patient care occurred through case conferences for 10 of 15 patients (#1, 2, 5, 6, 7, 8, 12, 13, 14, 15). Findings include: Patients #1, 2, 6, 12, 13, 14 and 15 were seen by SN and PT.	G 144	A. The Agency will ensure that case conferences occur as evidenced by completed documentation in the clinical records. Disciplines will be required to document communication with other disciplines on visit notes every two (2) weeks, and as needed for any changes in the patient's condition or Plan of Care. A written case conference form will be completed every two (2) weeks, and as needed per change in the Plan of Care. Patients 1,2,6,12,13,14 & 15 have all been discharged. All current and future patients will be affected by this corrective action. B. All patients' clinical records will be monitored concurrently for compliance with Case Conference Notes by the QA staff who will report to the Clinical Director. C. The Agency has scheduled a mandatory in-service for all disciplines on case conference/documentation of these conferences. This in-service was presented by the Clinical Director on May 8, 2009 (See Agenda - Attachment A). The Agency plans to repeat this in-service during the week of May 11-15, 2009 with mandatory attendance by <u>all</u> disciplines documented. QA staff has been instructed on monitoring compliance with case conferences.	

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G 144	Continued From page 6 Patient #5 was seen by SN, PT and occupational therapy (OT). Patient #7 was seen by SN, PT and certified nursing assistant (CNA). Patient #8 was seen by SN, CNA, PT and OT. The clinical records for Patients #1, 2, 5, 6, 7, 8, 12, 13, 14 and 15 lacked documentation indicating case conferences occurred. On 3/27/09 at 11:30 AM, the Director of Nurses indicated case conference occurred "every month."	G 144	D. Monitoring the corrective action will be accomplished by tracking of written case conference forms by the Clinical Director and QA staff. In addition, the QA staff will monitor the documentation of verbal communication/coordination between disciplines, and intervene as necessary. E. The Clinical Director will be responsible for monitoring compliance of this corrective action. The QA staff will assist and report to the Clinical Director in monitoring the corrective action. In addition, the Clinical Director/QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of Completion: June 19, 2009	
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to provide the physician with a written summary report every 60 days for 6 of 15 patients (#1, 2, 5, 6, 7, 8). Findings include: The clinical records for patients #1, 2, 5, 6, 7 and 8 contained a document titled "60-day Summary." The document for each patient included the diagnoses, the services provided by the agency and the care the patients continued to require. The 60-day Summaries for patients #1, 2, 5, 6, 7 and 8 lacked documentation indicating the progress (or lack thereof) made by these patients.	G 145	A. The Agency will ensure that documentation on the 60-day summary of care includes documentation of progress or lack of progress made by the patients. B. Compliance with this correction will be verified by QA monitoring of the documentation provided for all patients. C. The Agency held a mandatory in-service for all disciplines on proper documentation on the 60-day summary on May 8, 2009 (See Agenda Attachment A). This in-service will be repeated by the Clinical Director during the week of May 11-15, 2009, with mandatory attendance by all disciplines documented. QA staff will be instructed on monitoring compliance with the 60-day summary, and report any problems/issues to Clinical Director for immediate resolution. D. Monitoring the corrective action will be accomplished by review of 60-day summaries by the QA staff that will report to the Clinical Director and intervene as necessary.	

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G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure care followed a written plan of care established by the physician for 9 of 15 patients (#1, 2, 5, 6, 7, 8, 11, 14, 15). Findings include: Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin dependent diabetes mellitus. Patient #1's plan of care indicated the patient was to be weighed weekly. All skilled nursing visit notes lacked documentation indicating the patient was ever weighed. Patient #2 The start of care for Patient #2 was 11/11/08. Diagnoses included long term current use of anticoagulants, deep vein thrombosis (DVT) site not specified and chronic pulmonary obstructive disease (COPD). The start of care orders called for Patient #2 to receive Lovenox 100 milligrams subcutaneously twice a day for three days and Coumadin 7.5 milligrams by mouth every day.	G 158	A. The Agency will ensure that all physician orders are followed as written per the Plan of Care. Orders obtained will be specific in regards to wound care, PT/INR testing, frequencies of visits by disciplines, frequencies of wound care or Foley care, etc. Any missed visits will be communicated to the physician and an order for any change in frequency will be obtained. CNA care plans will be completed for all patients receiving CNA services. The Agency will ensure that all discipline frequencies are followed per plan of care. Patients 1,2,5,6,8,14 & 15 have been discharged. Orders for all care of patients 7 & 11 will be obtained as well as for all current and future patients who would benefit from this corrective action. B. The Agency will obtain physician orders for all care and will coordinate with the physicians to ensure all orders are specific and carried out per plan of care. Physician orders will be obtained consistently for any changes in the patients' POC. C. The Agency scheduled a mandatory in-service for all disciplines on MD orders/Plan of Care on May 8, 2009 (See Agenda - Attachment A). This in-service will be repeated by the Clinical Director during the week of May 11-15, 2009, with attendance by all disciplines documented. QA staff has been instructed to monitor visits and clinical notes to ensure all services comply with physician orders/Plans of Care. The Clinical Director will continue to QA all physician's orders/POCs.	

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The start of care orders indicated Patient #2 was to have "PT/INR (lab draw) per MD order."

The clinical record lacked documented evidence indicating the SN called the physician to ask for specific orders for a frequency of lab draws.

Note: Patient #2 was admitted to an acute care facility six days after start of care with an INR of 11. The target range of INR for a patient with DVT is between two and three.

Patient #5

The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure, hypertension, difficulty walking and bladder incontinence.

Patient #5's initial plan of care indicated the patient was to be weighed weekly. The skilled nurses visit notes lacked documentation indicating the patient was ever weighed.

On 1/22/09, the licensed practical nurse (LPN) documented Patient #5 had a pressure sore in the coccyx area.

On 1/22/09, the LPN wrote the following orders: "Cleanse coccyx wound with NS (normal saline) pat dry apply Hydrogel cover with gauze secure with tape q (every) day."

The order did not indicate skilled nursing (SN) was to teach a caregiver how to perform the wound care. The order did not indicate the SN frequency was to increase to daily.

D. Monitoring the corrective action will be accomplished by QA of the plan of care by the Clinical Director. The QA staff will assist the Clinical Directory by monitoring clinical notes to ensure compliance. The QA staff will also assist the Clinical Director by monitoring documentation to show that orders and visit frequencies are being followed, missed visits are communicated to the physician and patient care is delivered per plan of care established by the physician. The QA staff will report any problems/issued immediately to the Clinical Director for immediate resolution.

E. The Clinical Director will be responsible for monitoring and ensuring compliance of all patients' written plan of care/MD orders. QA staff will assist the Clinical Director by monitoring visit frequencies and notifying the physician of missed visits. The QA staff will report to the Clinical Director of any changes in frequencies or problems with compliance to the plan of care. The Clinical Director/licensed discipline will prepare a revised interim order for the changes in the plan of care to be signed by the MD. The Clinical Director will intervene if orders are not being followed per plan of care. The Clinical Director will monitor that a CNA care plan is completed and followed for each patient as indicated. In addition, the Clinical Director/QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action.

F. Date of completion: June 19, 2009

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G 158	Continued From page 9 The LPN saw Patient #5 on 1/29/09. The RN saw the patient on 2/7/09 for recertification. The recertification orders written by the RN read, "Cleanse wound with saline, pat dry, apply bacitracin ointment and Duoderm/Flexicol dressing." The orders did not include the frequency with which the dressing was to be changed. The orders did not include who was to change the dressing. Patient #6 The start of care for Patient #6 was 10/6/08. Diagnoses included hypertension, urinary retention and non insulin dependent diabetes mellitus. The plan of care for the certification period 12/5/08 - 2/2/09 indicated Patient #6 was to be seen by SN two times a week for two weeks and then, one time a week for seven weeks. According to the documentation in the clinical record, the actual frequency for SN was one time a week for eight weeks. The clinical record lacked documentation indicating the physician was made aware of (and signed orders for) the change in SN frequency for Patient #6. Patient #7 The start of care for Patient #7 was 12/18/08. Diagnoses included hypertension, congestive heart failure, insulin dependent diabetes mellitus, muscle weakness and difficulty walking.	G 158		

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G 158	Continued From page 10 Patient #7's plan of care indicated the patient was to be weighed weekly. One out of six skilled nursing visit notes (from 12/18/08 - 2/11/09) had a weight documented. The second certification period (2/16/09 - 4/16/09) plan of care indicated Patient #7 was to be weighed weekly. There was no documentation on the skilled nursing visit notes indicating the patient was weighed. PT evaluated Patient #7 on 2/16/09. The physician's order indicated PT would see the patient two times a week for five weeks. On 2/23/09, PT wrote an MVR. The clinical record lacked documentation indicating the physician was aware of (and signed orders for) the change in PT frequency for Patient #7. On 2/11/09, the RN completed a recertification visit and orders for the period 2/16/09 - 4/16/09. The SN frequency for Patient #7 was to be two times a week for one week and then, one time a week for eight weeks. Patient #7's clinical record contained a SN MVR dated 2/20/09. The clinical record lacked documentation the physician was aware of (and signed orders for) the change in SN frequency for Patient #7. As of 3/31/09, Patient #7's clinical record lacked a completed CNA care plan. Patient #8 The start of care for Patient #8 was 11/12/08. Diagnoses included arthritis, difficulty walking and	G 158		

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G 158	Continued From page 11 history of falls. On 11/14/08, the physical therapist (PT) performed an evaluation. The PT frequency ordered was once a week for one week and three times a week for four weeks. Patient #8's clinical record contained an MVR for 11/24/08. The clinical record contained one physical therapy revisit note for the week of 11/12/08. The clinical record lacked three PT re-visit notes for the week of 11/30/08. The clinical record lacked documentation indicating the physician was made aware of (and signed orders for) the change in PT frequency for Patient #8. On 12/7/08, Patient #8 was admitted to the hospital after sustaining a fall. On Friday, 12/19/08, the registered nurse (RN) completed a resumption of care (ROC) visit for Patient #8. The ROC frequency for the certified nursing assistant (CNA) was ordered for two times a week for two weeks. The actual frequency of CNA visits made for Patient #8 after the ROC was once a week for one week, two times a week for one week and one time a week for one week, beginning on Saturday, 12/27/08. The clinical record lacked documentation indicating the physician was made aware of (and signed orders for) the change in CNA frequency for Patient #8. Patient #11	G 158		

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G 158	Continued From page 12 The start of care for Patient #11 was 2/21/09. Diagnoses included a sacral pressure ulcer, insulin-dependent diabetes mellitus and coronary artery disease. Patient #11's clinical record contained orders for SN one time a week for one week, two times a week for two weeks and then, one time a week for 6 weeks. Patient #11's clinical record contained a SN MVR, dated 3/6/09. The clinical record lacked documented evidence the physician was made aware of (and signed orders for) the change in SN frequency for Patient #11. Patient #11's clinical record contained orders for CNA two times a week for eight weeks, beginning the week of 2/22/09. Patient #11's clinical record contained a CNA MVR, dated 3/6/09. The clinical record lacked documented evidence the physician was made aware of (and signed orders for) the change in CNA frequency for Patient #11. Patient #14 The start of care for Patient #14 was 2/25/09. Diagnoses included multiple sclerosis, hypertension and coronary disease. On 2/27/09, the LPN wrote an MVR for Patient #14. The clinical record lacked documentation indicating the physician was made aware of (and signed orders for) the change in SN frequency. Patient #15	G 158		

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G 158	Continued From page 13 The start of care for Patient #15 was 2/24/09. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, hypertension and insulin dependent diabetes mellitus. PT orders for Patient #15 were one time a week for one week and then, two times a week for five weeks. On 3/1/09, 3/10/09 and 3/14/09, the PT wrote MVRs. The clinical record lacked documentation indicating the physician was made aware of (and signed orders for) the change in PT frequency. Note: The agency's week began on Sunday	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on interview and clinical record review, the facility failed to ensure the plan of care included all pertinent diagnoses for 1 patient (#15). Findings include: Patient #15	G 159	A. The Agency will ensure that all pertinent and significant diagnoses will be included in the plan of care. The agency will request all pertinent information from referral sources (i.e.: hospitals, MD offices, etc.) to include information such as history and discharge instructions whenever a patient is referred to the Agency. Patient 15 has already been discharged from home care. All current and future patients will be affected by this corrective action. B. The Agency will confirm all hospital/physician/facility, etc. referrals and obtain all pertinent information including medical history/doctor discharge instructions, etc. for all patients receiving care. C. Intake staff will be instructed to request history, diagnosis, and other significant information from the referring M.D. and referral sources for all patients. The office manager will track all hospitalized patients and request medical history, diagnosis and discharge instructions from the hospital for all hospital discharged patients receiving agency care. The start of care nurse will also obtain a pertinent history and significant diagnosis from the patient or caregiver at the start of care, and document in the start of care packet. All pertinent diagnoses will be added to the POC during e patients episode as indicated with a physician's order. An in-service has been held on May 8, 2009 to instruct all staff (visiting and office) on this corrective plan of action (See Agenda - Attachment A). The same in-service will be repeated during the week of May 11-15, 2009 with mandatory attendance documented.	

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G 159	Continued From page 14 The start of care for Patient #15 was 2/24/09. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, hypertension and insulin-dependent diabetes mellitus. Patient #15 was on an anti-seizure medication. The plan of care did not include seizure disorder as one of the diagnoses. On 3/27/09 at 10:40 AM, the director of nursing indicated the agency had not requested additional documentation from physicians' offices or hospitals (history and physical, discharge summaries, etc.) when they received referrals for their services	G 159	D. The Clinical Director will continue to QA all plans of care to ensure that all pertinent diagnosis are included especially for any medications that are prescribed. The plan of care will be provided to all disciplines performing services to the patients. All pertinent diagnoses will be added with a physician's order as indicated. E. The Clinical Direction will be responsible for the Plan of Care with assistance from the QA staff, intake, and SOC nurse. All staff (visiting and office) have been instructed on the Plan of Care and importance of all significant/pertinent diagnoses documented as obtained by the visiting nurse. In addition, the Clinical Director/QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F Date of Completion: June 19, 2009	
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on interview and clinical review, the agency failed to ensure the physician was consulted to modify the original plan of care for 4 of 15 patients (#1, 3, 7, 10). Findings include: Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin dependent diabetes mellitus. The plan of care included a physical therapy (PT)	G 160	A. The intake staff will assign therapy cases to the Therapists immediately to allow the therapist to do an evaluation within 72 hours of the Start of Care. The Physician and other disciplines will be notified of any delay in therapy evaluations and this communication will be documented in the clinical record. An interim order will be completed as indicated. B. Therapists will be instructed to complete evaluations within 72 hours of MD referral, or communicate with the physician and disciplines to notify of any delay. Intake staff will be instructed to assign therapy cases immediately following therapy referrals and notify the Clinical Director of any problem or concerns. C. The Agency will initiate a coordinated plan of correction to ensure therapy evaluations are completed in a timely manner (within (72 hours of receipt of referral). Intake staff and Clinical Director will monitor initial MD orders for therapy. Start of Care nurses will coordinate with the physician and notify the intake staff when therapy is required. Intake will then assign cases to Therapy in a timely manner and monitor the date of initial evaluations by the Therapists. The Agency has scheduled a mandatory in-service on May 8, 2009 to present the Plan of Correction. This same in-service will be repeated during the week of May 11-15, 2009 to present this Plan of Correction, and obtain feedback from the staff. Attendance will be documented. (See Agenda - Attachment A).	

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G 160	Continued From page 15	G 160		

evaluation. The PT evaluation was performed 15 days after the start of care. The clinical record lacked documentation the physician was notified of the delay of the PT evaluation.

According to the Agency's Policy Number 3.1, Assessments, effective 6/22/06, "...Therapies (PT, ST and OT) and MSW: Within 72 hours (following receipt of initial or subsequent referral)."

On 3/27/09 in the morning, the director of nursing indicated their policy allowed PT and occupational therapy (OT) "up to 48 hours" after the start of care to perform an evaluation.

Patient #3

The start of care for Patient #3 was 3/20/09. Diagnoses included paralysis agitans (Parkinson's disease) and difficulty walking.

The start of care orders for Patient #3 included PT and OT evaluations.

According to the clinical record, PT saw Patient #3 for an evaluation four days after the start of care. OT saw the patient for an evaluation five days after the start of care.

The clinical record for Patient #3 lacked documentation indicating the physician was notified of the delay in the PT and OT evaluations.

Patient #7

The start of care for Patient #7 was 12/18/08. Diagnoses included hypertension, congestive

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G 160	Continued From page 16 heart failure, insulin dependent diabetes mellitus, muscle weakness and difficulty walking. On 12/18/08, a PT evaluation was ordered for Patient #7. The clinical record contained four missed visit reports. The clinical record lacked documentation indicating the physician was notified of the delay in treatment. On 2/16/09, Patient #7 was evaluated by PT. Patient #10 The start of care for Patient #10 was 3/13/09. Diagnoses included generalized pain, hypothyroidism, muscle weakness and history of a fall. The plan of care called for skilled nursing services and a PT evaluation. A communication note written by the intake coordinator on 3/24/09, indicated PT was unable to see Patient #10 as the patient was not at the address of record. The clinical record lacked documentation indicating the physician was notified of PT's inability to see and evaluate the patient.	G 160	D. The QA/Intake staff will monitor initial evaluations by the Therapist to ensure that initial evaluations are completed within 72 hours and visits are completed per therapy treatment plan. Therapists will notify Physicians and other disciplines when visits are delayed and an order will be obtained for the change in the Plan of Care. E. The Clinical Director with the assistance of the QA/Intake staff will monitor compliance of the timeliness of Therapy evaluations per Agency policy. Therapist will be required to notify the Physician of any delay in initial evaluation or missed visits and obtain an order for a change in schedule. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of complete: June 19, 2009	
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, the facility failed to	G 166	A. Physician signatures and dates on all plans of care and interim orders will be obtained within 30 days per agency policy. Both patients 5 and 8 have already been discharged. All current and future patients will be affected by this corrective action. B. All plans of care and interim orders sent to physicians for signatures will be tracked by the office manager to ensure that these are signed and dated within 30 days. The Clinical Director will monitor and track the compliance of the return of signatures and dates on all Plans of Care and interim orders on a quarterly basis.	

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G 166	Continued From page 17 ensure verbal orders were signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services for 2 of 15 patients (#5, 8). Findings include: Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure, hypertension, difficulty walking and bladder incontinence. Patient #5's clinical record contained a plan of care for the certification period of 12/13/08 - 2/10/09. The area for the physician's signature and date was blank. Patient #5's clinical record contained a plan of care for the period 2/11/09 - 4/11/09 and a physician's order for wound care, both written on 2/11/09. As of 3/31/09, both orders lacked the physician's signature and date. Patient #8 The start of care for Patient #8 was 11/12/08. Diagnoses included arthritis, difficulty walking and history of falls. On 1/12/09, the physical therapist (PT) performed a recertification assessment of Patient #8. On the second page of the assessment, the areas for 1) frequency of visits and 2) duration of treatment were blank. The areas for the physician's signature and date were blank as of 3/31/09.	G 166	C. The Agency will continue to track and monitor the timeliness of retuned Physician signatures and dates on all plans of care and interim orders within 30 days per Agency policy. Agency marketers will be instructed to follow-up with Physicians to obtain the signed and dated orders within the 30 day time frame per Agency policy. An in-service for office staff and marketers was held May 8, 2008 (See Agenda - Attachment A). The Agency plans to repeat this same in-service during the week of May 11-15, 2009 with mandatory attendance documented. D. The Clinical Director will prepare quarterly reports to monitor compliance with the 30 day policy for signed and dated plans of care and interim orders. E. Agency office staff, marketers and the Clinical Director are responsible to ensure that plans of care and visiting interim orders are signed and dated within the 30 days time frame per Agency policy. The Clinical Director will monitor the Agencies compliance with this standard through tracking/monitoring on a quarterly basis. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of completion: June 19, 2009.	
G 169	484.30 SKILLED NURSING SERVICES	G 169	A. LPNs and home health aids (CNA's) will immediately	

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G 169	Continued From page 18 The HHA furnishes skilled nursing services by or under the supervision of a registered nurse. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse made a visit to the home no less than every two weeks for 5 of 15 patients (#1, 5, 13, 14, 15). Findings include: Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin dependent diabetes mellitus. The registered nurse (RN) saw Patient #1 for the start of care visit on 6/20/08. During the next eight weeks, the licensed practical nurse (LPN) saw the patient for ten consecutive visits. Patient #1's clinical record lacked documented evidence that a supervisory visit was completed by the RN with the LPN. Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure, hypertension, difficulty walking and bladder incontinence. The RN saw Patient #5 for the start of care visit on 12/13/08. During the next four weeks, the LPN saw the patient seven consecutive times.	G 169	be supervised every fourteen (14) days and as needed. This will be evidenced by supervisory documentation on the supervisory portion of the clinical notes. Patients 1,5,13,14 and 15 have all been discharged. All current and future patients will be affected by this corrective action. B. The Agency will ensure compliance for supervision of LPNs and HHAs through QA monitoring of documentation of this supervision in the clinical record. C. The Agency has scheduled a mandatory in-service for all disciplines to review policies on LPN/HHA supervision. RNs have been instructed on LPN/HHA supervisory visits and documentation of this supervisory visit. QA staff have been instructed to monitor documentation of LPN/HHA supervision. The Agency has scheduled an in-service on May 8, 2009, (See Agenda - Attachment A) and during the week of May 11-15, 2009 with attendance by all disciplines documented. D. Monitoring of LPN/HHA supervision will be performed by the QA staff. The QA staff will monitor the supervisory documentation and report any problems/issues to the Clinical Director for immediate resolution. E. The Clinical Director will be responsible for LPN/HHA supervision with assistance of visiting RN nurses. The QA staff will be responsible to monitor the supervisory documentation in the clinical records, and report any non-compliance immediately to the Clinical Director for resolution. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of completion: June 19, 2009.	

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G 169	Continued From page 19 Patient #5's clinical record lacked documented evidence that a supervisory visit was completed by the RN with the LPN. Patient #13 The start of care for Patient #13 was 1/28/09. Diagnoses included abscess to the buttock area, chronic pain, fibromyalgia and difficulty walking. The RN saw Patient #13 for the start of care visit on 1/28/09. During the next six weeks, the LPN saw the patient seven consecutive times. Patient #13's clinical record lacked documented evidence that a supervisory visit was completed by the RN with the LPN. Patient #14 The start of care for Patient #14 was 2/25/09. Diagnoses included multiple sclerosis, hypertension and coronary disease. The RN saw Patient #14 for the start of care visit on 2/25/09. During the next three weeks, the LPN saw the patient four consecutive times. Patient #14's clinical record lacked documented evidence that a supervisory visit was completed by the RN with the LPN. Patient #15 The start of care for Patient #15 was 2/24/09. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, hypertension and insulin dependent diabetes mellitus.	G 169		

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G 169	Continued From page 20 The RN saw Patient #15 for the start of care visit on 2/24/09. During the next three weeks, the LPN saw the patient five consecutive times. Patient #15's clinical record lacked documented evidence that a supervisory visit was completed by the RN with the LPN.	G 169		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the registered nurse (RN) regularly re-evaluated the nursing needs for 3 of 15 patients (#1, 5, 13). Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin dependent diabetes mellitus. The licensed practical nurse (LPN) saw Patient #1 once a week for eight consecutive weeks. The clinical record lacked documentation the RN re-evaluated the patient's needs during the eight weeks. On 7/28/08 and 8/4/08, the LPN documented Patient #1 had edema (swelling) in the lower legs. The clinical record lacked documentation indicating the RN was notified. The clinical record lacked documentation indicating the RN	G 172	A. A registered nurse (RN) will re-evaluate the patient on a regular basis (every 14 days) or when a change occurs in the patient's condition. When a LPN is scheduled to service a patient, a RN will evaluate the patient every 14 days or as often as necessary per changes in the patients condition. B. Visiting RNs will be re-evaluate the patient every 14 days or when the patient's condition changes. Visiting LPNs, Therapists, and all other disciplines will immediately report changes in the patient's condition to the Clinical Director/RNs and the patient will be immediately re-evaluated, and coordination with the Physician completed as indicated. C. The Agency has scheduled a mandatory in-service on May 8, 2009 (See Agenda - Attachment A), to instruct all disciplines on re-evaluating and reporting changes in the patient's needs, condition and plan of care as well as a RN reevaluating a patient every 14 days ~~weekly~~ on a regular basis and ~~as~~ needed. The Agency plans to hold the same mandatory in-service during the week of May 11-15, 2009. This in-service will be presented by the Clinical Director. D. All visiting Nurses, Therapists and Home Health Aids will report changes in the patients' condition or needs immediately to the Clinical Director. The Clinical Director will ensure that all patients are re-evaluated on a regular basis (every 14 days) and as necessary. QA staff will monitor clinical notes and report changes in the patients' condition or needs to the Clinical Director. RN's will be assigned to re-evaluate patients every 14 days or as needed per changes in the patient's condition. E. The Clinical Director will be responsible for monitoring re-evaluation of patients' needs or change in plan of Care with the assistance or Nurses, Therapist, Home Health Aids and the QA staff. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action.	

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G 172	Continued From page 21 re-evaluated the patient's needs. Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure, hypertension, difficulty walking and bladder incontinence. The RN saw Patient #5 for the start of care evaluation. The LPN saw the patient 10 consecutive times. In the sixth full week of Patient #5's certification period, the patient developed a pressure ulcer to the sacral/coccygeal area. The clinical record lacked documentation indicating the RN re-evaluated the patient's needs during this time. After the RN completed a recertification assessment and care plan on 2/7/09, the LPN saw Patient #5 eight consecutive times. During this time (six weeks), the patient developed blisters on the upper back which then opened and had bloody drainage. The clinical record lacked documentation indicating the RN re-evaluated Patient #5's needs during this time. Patient #13 The start of care for Patient #13 was 1/28/09. Diagnoses included abscess to the buttock area, chronic pain, fibromyalgia and difficulty walking. After the RN completed the initial assessment on Patient #13, the LPN saw the patient seven times over six weeks. The clinical record lacked documentation	G 172		

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G 172	Continued From page 22 indicating the RN re-evaluated Patient #13's needs during this time.	G 172	F. Date of completion: June 19. 2009.	
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by. Based on clinical record review, the registered nurse (RN) failed to initiate revisions to the plan of care for 2 of 15 patients (#2, 5). Findings include: Patient #2 The start of care for Patient #2 was 11/11/08. Diagnoses included long term current use of anticoagulants, deep vein thrombosis (DVT) and chronic pulmonary obstructive disease. The start of care orders called for Patient #2 to receive Lovenox 100 milligrams subcutaneously twice a day for three days and Coumadin 7.5 milligrams by mouth every day. The start of care orders indicated Patient #2 was to have "PT/INR (lab draw) per MD order." The clinical record lacked documented evidence indicating the skilled nurse (SN) called the physician to ask for specific orders for a frequency of lab draws. Note: Patient #2 was admitted to an acute care facility six days after start of care with an INR of 11. The target range of the INR for a patient with	G 173	A. At the start of care the RN will initiate the plan of care and initiate revisions to this plan of care as deemed necessary. The physician will be contacted for specific orders (i.e.: frequency of labs, etc.). Documentation of all orders will be specific and detailed. All current and future patients will be affected by the corrective action. Patients 2 and 5 have already been discharged. B. The Clinical Director will monitor all initial/concurrent physician orders and plans of care to ensure that all physician orders are complete, specific and accurate. C. The Agency has scheduled a mandatory in-service on May 8, 2009 for all appropriate disciplines (See Agenda - Attachment A). This in-service included instruction on complete, specific and accurate orders. The Agency plans to hold the same in-service during the week of May 11-15, 2009 with mandatory attendance by all disciplines documented. This in-service will also be presented by the Clinical Director. D. All initial/concurrent physician orders and plans of care have been reviewed by the Clinical Director and corrected as needed. This corrective action will continue and for all current and future patients to ensure all POCs/revisions are initiated as indicated. E. The Clinical Director is responsible for all reviewing of physician orders and plans of care. QA staff and RNs will assist in ensuring that all physician orders and plans of care are complete, specific and accurate, and report any problems/issues to the Clinical Director. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of completion: June 19, 2009	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297104	A. BUILDING _____ B. WING _____	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICE	3960 EAST PATRICK, #202 LAS VEGAS, NV 89120

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G 173	Continued From page 23 DVT is between two and three. Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure, hypertension, difficulty walking and bladder incontinence. The start of care orders for Patient #5 read, "...Change cath (indwelling urinary catheter) every month inflated with 30 cc (cubic centimeters) balloon..." The start of care orders for Patient #5 lacked the specific size of the catheter and amount of solution to instill into the 30 cc balloon. The recertification orders for the two periods of 12/5/08 - 2/2/09 and 2/3/09 - 4/3/09 both read, "...Change cath (indwelling urinary catheter) every month inflated with 30 cc (cubic centimeters) balloon..." The recertification orders lacked the specific size of the catheter and amount of solution to instill into the 30 cc balloon. Patient #5's clinical record contained a skilled nursing (SN) note dated 12/26/08 which read, "Catheter re-inserted using French #16 with 30 cc distilled water . . ." Patient #5's clinical record contained a SN note dated 1/8/09 which read, "...changed catheter to French #18 with 30 cc distilled water in balloon ..." After the start of care was completed by the RN, the licensed practical nurse (LPN) saw Patient #5 eight consecutive times.	G 173		

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G 173	Continued From page 24 Patient #5's clinical record lacked documentation indicating the RN had contacted the physician to obtain specific orders for the size of the catheter, balloon and amount of fluid to be instilled into the balloon. Patient #5's clinical record contained a SN note dated 3/5/09 which read, "...catheter removed and replaced with #18 French with 30 milliliters balloon..." Patient #5's clinical record lacked documentation indicating the RN contacted the physician to initiate the necessary revisions to Patient #5's plan of care.	G 173		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical record review, the facility failed to ensure the registered nurse informed the physician of changes in condition and needs for 4 of 15 patients (#1, 2, 5, 6). Findings include: Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin dependent diabetes mellitus.	G 176		

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G 176	Continued From page 25 Skilled nursing visit notes written by the licensed practical nurse (LPN), dated 7/28/08 and 8/4/08, indicated Patient #1 was experiencing edema (swelling) in both lower extremities. Patient #1's clinical record lacked documentation the LPN notified the registered nurse of the changes. Patient #2 The start of care for Patient #2 was 11/11/08. Diagnoses included long term current use of anticoagulants, deep vein thrombosis (DVT) site not specified and chronic pulmonary obstructive disease (COPD). The start of care orders called for Patient #2 to receive Lovenox 100 milligrams subcutaneously twice a day for three days and Coumadin 7.5 milligrams by mouth every day. The start of care orders indicated Patient #2 was to have "PT/INR (lab draw) per MD order." The clinical record lacked documented evidence indicating the SN called the physician to ask for specific orders to draw a PT/INR. Note: Patient #2 was admitted to an acute care facility six days after start of care with an INR of 11. The target range of INR for a patient with DVT is between two and three. Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure (CHF), hypertension, difficulty walking and	G 176	A. The LPN will immediately report any changes in the patient's condition to a registered nurse (RN) and/or the Clinical Director. The RN/Clinical Director will then immediately inform the physician of the changes in the patient's condition or needs and coordinate all necessary changes in the Plan of Care with the physician and disciplines. Changes in the Plan of Care will be communicated to all disciplines involved in the patient episode. In addition, all RNs will obtain complete, specific and accurate orders from the physician at the start of care and as deemed necessary per changes in the Plan of Care. All current and future patients will benefit from this corrective action. Patients 1,2,5 and 6 have all been discharged from home health services. B. All clinical notes will be ~~immediately~~ cc concurrently monitored by QA staff to ensure that physicians have been notified for all changes in the patient's condition. All interim orders will be monitored/evaluated by the Clinical Director for completeness, accuracy, and follow-through. C. The Agency has scheduled a mandatory in-service on May 8, 2009 (See Agenda – Attachment A), for all appropriate disciplines on the process of notifying the RN/Clinical Director/Physician for all changes in the patient's condition, as well as the documentation and communication of these changes in the plan of care. The Agency plans to hold an additional mandatory in-service during the week of May 11-15, 2009 with attendance by all disciplines documented. This in-service will be presented by the Clinical Director.	

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G 176	Continued From page 26 bladder incontinence. On 1/22/09, the LPN documented Patient #5 had an open wound on the sacrum. There was no indication the RN (or physician) was notified of the change in condition. The LPN documented wound dimensions (length and width) on 1/29/09, 2/15/09, 2/12/092/18/09, 2/27/09. The documentation lacked indication the RN (or physician) was notified. On 3/4/09, the LPN documented patient #5's sacrum was healed. The LPN documented the patient had a wound (no measurements) on the left upper back with bloody drainage. The skilled nurse visit note lacked documentation indicating the RN (or physician) was notified of the new wound. On 3/11/09, the LPN documented Patient #5 had a right upper back wound (no measurements, no mention of drainage). On 3/17/09, the LPN documented the patient had a wound on the right upper back measuring "1.5 in size, 0.5 in depth with bloody drainage." Patient #6 The start of care for Patient #6 was 10/6/08. Diagnoses included hypertension, urinary retention, blindness and non-insulin dependent diabetes mellitus. After the registered nurse (RN) admitted Patient #6, the LPN saw the patient six times. The patient refused to allow the LPN to check the blood glucose level all six times. The clinical record lacked documentation indicating the nurse	G 176	D. The Clinical Director and the QA staff will accomplish monitoring this corrective action. The QA staff will review all clinical notes on a concurrent basis. The Clinical Director will monitor/evaluate all physician orders as well as receiving communication from disciplines reporting changes on the patient's condition or needs and coordinate/document these changes per Agency process mentioned previously. E. The Clinical Director will be responsible for monitoring compliance of this corrective action. The QA staff and visiting staff will assist and report to the Clinical Director. Compliance with this corrective action will be reported monthly to the PI committee. F. Date of completion: July 19, 2009	

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G 176	Continued From page 27 notified the physician of the patient's refusals to allow blood glucose checks. According to a communication note, dated 10/13 and 10/15/08, the LPN notified the director of nursing (DON) that Patient #6 was refusing to let the LPN check blood glucose levels. The clinical record lacked documentation indicating the DON notified the physician of the patient's refusals.	G 176		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on clinical record review, the registered nurse (RN) failed to counsel (instruct) the caregiver how to provide wound care for 1 of 15 patients (#5). Findings include: Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure, hypertension, difficulty walking and urinary incontinence. The clinical record for Patient #5 contained an order dated 1/22/08 which read, "Cleanse coccyx wound with normal saline, pat dry, apply Hydrogel, cover with gauze, secure with tape every day." The clinical record lacked documentation indicating the RN taught Patient #5 and/or the	G 177	A. The registered nurses (RNs) and licensed practical (LPNs) nurses will immediately instruct/counsel patients and caregivers regarding the plan of care and related needs including medications, diet, disease process, safety, infection control, health maintenance, wound care, Foley care, pain management etc. The goal is to assist the patient and caregivers to achieve independent in care including return demonstrations of all treatments as necessary. Patient number 5 has already been discharged from home health services, however all current and future patients will be affected by this corrective action. B. The QA staff will monitor all clinical notes for evidence of documentation of teaching, instruction, and return demonstrations regarding the patient's needs. C. The Agency has scheduled a mandatory in-service on May 8, 2009 for all appropriate disciplines (See Agenda – Attachment A). This in-service covered teaching/instruction and documentation of teaching/counseling of patients and caregivers. This in-service was presented by the Clinical Director. The Agency plans to hold the same in-service during the week of May 11-15, 2009 with mandatory attendance by all disciplines documented. D. The QA staff will monitor all clinical notes for documentation of teaching/instruction and return demonstrations of the patients and caregivers and will report to the Clinical Director any problems/issues noted for immediate resolution.	

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G 177	Continued From page 28 caregiver how to care for the wound. The clinical record lacked documentation indicating the licensed practical nurse taught Patient #5 and/or the caregiver how to care for the wound. The clinical record lacked documentation indicating Patient #5 and/or the caregiver were able to return demonstrate the wound care process.	G 177	E. The Clinical Director is responsible for ensuring that teaching/instructing the patient and/or caregivers is being performed for all patients/caregivers. The Clinical Director will be assisted by the QA staff in monitoring all clinical notes for evidence of teaching/instructing/counseling/return demonstrations for all patients/caregivers. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of correction: June 19, 2009	
G 178	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the registered nurse (RN) performed supervisory visits of the licensed practical nurse (LPN) for 1 of 15 patients (#1). Findings include: Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin dependent diabetes mellitus. The plan of care indicated the SN frequency was one time a week for one week, two times a week for two weeks and then, one time a week for six weeks. The RN performed the first (start of care) visit. The LPN saw the patient for the duration of	G 178	A. Agency in-services are provided for all disciplines and attendance is documented on a regular basis (at least monthly). RNs/Clinical Director will supervise and instruct LPNs and CNA/HHAs on patient care every 14 days and as needed per changes in the plan of care, and as needed by the disciplines. Patient number 1 has already been discharged from home health services, however all current and future patients will be affected by this corrective action. B. The Agency will ensure compliance for supervision of LPNs, HHAs and CNA through QA monitoring of documentation of this supervision in the clinical records. C. The Agency has scheduled a mandatory in-service on May 8, 2009 (See Agenda – Attachment A) for all disciplines to review policies on LPN/CNA/HHA supervision. The QA staff has been instructed to monitor documentation of LPN/CNA/HHA supervision. All RNs have been instructed on LPN/CNA/HHA supervisory visits and documentation of this supervision. The Clinical Director presented the in-service. The Agency plans to hold this same in-service the week of May 11-15, 2009 with attendance by all disciplines documented. D. Monitoring the corrective action will be accomplished by QA staff concurrent review of clinical notes for evidence of documentation of LPN/CNA/HHA supervision and instruction as needed. QA staff will report to the Clinical Director for intervention as often as necessary or for immediate resolution of any problems/issues with non-compliance. E. The Clinical Director is responsible for monitoring compliance with this corrective action. QA staff will assist the Clinical Director by monitoring documentation on clinical notes for evidence of LPN/CNA/HHA supervision. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action.	

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G 178	Continued From page 29 the certification period. The clinical record lacked documentation the RN had performed a supervisory visit for the LPN.	G 178	F. Date of completion: June 19, 2009	
G 185	484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review and document review, the agency failed to ensure services of a qualified therapist were delivered in accordance with the plan of care for 3 of 15 patients (#1, 3, 15). Findings include: Patient #1 The start of care for Patient #1 was 6/20/08. Diagnoses included hypertension, congestive heart failure and non-insulin dependent diabetes mellitus. The referral for Patient #1 was dated 6/19/08. The referral included skilled nursing (SN) and physical therapy (PT). The PT evaluation occurred 15 days after the nurse admitted the patient. Patient #1's clinical record lacked documentation indicating the physical therapist spoke with the physician regarding the delay in treatment.	G 185	A. Therapy services will immediately be provided according to physician orders and plans of care. Therapists will evaluate the patient within 72 hours of the Physician's referral. The Physician will be notified of any deviation/delay from this schedule and a new order for the revised plan of care obtained from the Physician and coordinated/documented with disciplines. Patients 1 and 15 have already been discharged from service. All current and future patients will be affected by this corrective action. B. When therapy services are ordered, the intake staff will immediately schedule a therapy evaluation. Therapists are required to notify the Physician and Clinical Director immediately for any delay in service (any evaluation that is not completed within 72 hours.) The Therapist/Clinical Director will follow protocol as mentioned above. C. The Agency has scheduled a mandatory in-service on May 8, 2009 for all appropriate disciplines (See Agenda – Attachment A). This in-service addressed timely scheduling (within 72 hours) of Therapy evaluations. Intake staff have been instructed to notify Therapists immediately of new Therapy evaluations. Therapists have been instructed to notify Physicians of any delay or deviation in the scheduling of their initial evaluation and document and coordinate this communication with the Physician and involved disciplines, as well as complete a physician order as indicated. The Agency will repeat this mandatory in-service during the week of May 11-15, 2009 with attendance by all disciplines documented.	

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G 185	Continued From page 30 Patient #3 The start of care for Patient #3 was 3/20/09. Diagnoses included paralysis agitans (Parkinson's disease) and difficulty walking. The referral for Patient #3 was dated 3/17/09. The referral included SN, PT and OT. The PT evaluation occurred four days after the nurse admitted the patient. The OT evaluation occurred five days after the nurse admitted the patient. Patient #15 The start of care for Patient #15 was 2/24/09. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, hypertension and insulin dependent diabetes mellitus. The referral for Patient #15 was dated 2/23/09. The referral included SN and PT. The PT evaluation occurred four days after the nurse admitted the patient. According to the agency's Policy Section: Assessments Patient Initial Assessments, Number: 3.1, effective 6/26/06, "...Therapies (PT, ST, and OT) and MSW: Within 72 hours (following receipt of initial or subsequent referral..."	G 185	D. Monitoring of this corrective action will be accomplished by the intake staff and QA staff. The QA staff will review the clinical notes and evaluations by the Therapists for compliance and intervention as necessary. The intake staff will monitor the timely scheduling of Therapy evaluations and report any problems or issues with delays immediately to the Clinical Director for appropriate intervention. E. The Clinical Director is responsible for monitoring compliance with this corrective action. The QA staff and intake staff will assist in monitoring the scheduling, documentation, and reporting immediately to the Clinical Director any problems or issues with timely scheduling of Therapy evaluations. The intake and QA staff and Clinical Director will report on the compliance of this corrective action monthly to the PI committee. D. Date of completion: June 19, 2009	
G 188	484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel This STANDARD is not met as evidenced by: Based on clinical record review, the therapist failed to consult with agency personnel regarding	G 188	A. The Agency will improve the liaison/communication between all disciplines (Therapist, Nurses, etc.) by mandating that communication occur at the start of care, every 2 weeks and as needed (i.e.; change in the patient's condition). All disciplines will document this communication on the clinical notes in the coordination of care box and on the case conference forms every two (2) weeks and as deemed necessary. Patients 8 and 15 have already been discharged from services. All current and future patients will benefit from this corrective action.	

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G 188	Continued From page 31 2 of 15 patients (#8, 15). Findings include: Patient #8 The start of care for Patient #8 was 11/12/08. Diagnoses included arthritis, difficulty walking and history of falls. Patient #8's clinical record contained an occupational therapy (OT) revisit note, dated 12/31/08. On the note, the OT wrote " Pt (patient) reported a fall from last night as she was trying to transfer onto commode..." Patient #8's clinical record lacked documented evidence the OT notified the registered nurse regarding the fall. Patient #15 The start of care for Patient #15 was 2/24/09. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, hypertension and insulin dependent diabetes mellitus. On 3/17/09, Patient #15 told the physical therapist (PT) she was afraid to be very active because activity might bring on a seizure. The clinical record lacked documentation indicating the PT spoke with the nurse regarding the patient's concern.	G 188	B. The Agency will ensure compliance with this corrective action by monitoring documentation in clinical notes by the QA staff and Clinical Director on a concurrent basis and intervention initiated as needed. C. The Agency has scheduled a mandatory in-service on May 8, 2009 for all disciplines on care coordination and documentation of this coordination (See Agenda – Attachment A). The Agency plans to hold the same in-service during the week of May 11-15, 2009 with attendance by all disciplines documented. This in-service will be presented by the Clinical Director. D. Monitoring the corrective action will be accomplished by QA staff's and Clinical Director's concurrent review of the disciplines' clinical notes and case conference notes with intervention initiated as needed. The QA staff will report any problems or issues immediately to the Clinical Director for resolution. Compliance with this corrective action will be reported on a monthly basis to the PI committee 1. E. The Clinical Director is responsible for monitoring compliance with this corrective action. The QA staff will assist and report to the Clinical Director as needed, but at least weekly, for on-going compliance. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of completion: June 19, 2009	
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective	G 337	A. The Agency requires a comprehensive assessment and drug regimen review to be completed on all patients at the start of care, resumption of care, recertification of care, and discharge from care. The comprehensive assessment/drug regimen is reviewed and updated per changes in the plan of care.	

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AT HOME HEALTH SERVICE	2721 E. Russell Road Las Vegas, NV 89120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 32 drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the comprehensive assessment included a review of all medications being used by 1 of 15 patients (#2). Findings include: Patient #2 The start of care for Patient #2 was 11/11/08. Diagnoses included long term current use of anticoagulants, deep vein thrombosis site not specified and chronic pulmonary obstructive disease. The start of care orders indicated Patient #2 was to receive Lovenox 100 milligrams subcutaneously twice a day for three days and Coumadin 7.5 milligrams by mouth every day. The clinical record lacked documented evidence the SN identified potential adverse effects related to the high doses of the two blood thinners and placed a call to the physician for verification.	G 337	All potential adverse effects related to the medication regimen are included in the start of care packet as well as given to the patients as indicated during the episode of care. Any problems (i.e. adverse effects) assessed by the clinical staff are immediately reported to the Physician for changes in the medication regimen and Plan of Care. Patient number 2 has already been discharged from care. All current and future patients will benefit from this corrective action. B. The Agency will ensure compliance for all patients through QA monitoring of documentation of identification of all adverse effects, drug reactions, ineffective drug treatment, significant side effects, etc. on the comprehensive assessment and drug regiment. This will be accomplished by the QA staff and the Clinical Director's initial/concurrent review of all comprehensive assessment of drug regimens. C. The Agency has scheduled a mandatory in-service on May 8, 2009 for all disciplines on medication documentation especially addressing potential adverse effects, drug reaction, ineffective drug treatment, significant side effects, etc. (See Agenda – Attachment A). The QA staff has been instructed to monitor the documentation and report any problems or issues to the Clinical Director The Clinical Director has presented this in-service. The Agency plans to hold same mandatory in-service during the week of May 11-15, 2009 with attendance by all disciplines documented. D. Monitoring this corrective action will be accomplished by QA staff and Clinical Director review of comprehensive medication including initial/concurrent potential adverse effects/drug reactions, ineffective drug therapy, significant side effects, etc. documentation and QA review of the plan of care by the Clinical Director. E. The Clinical Director is responsible for monitoring compliance with this corrective action. The QA staff will assist and report to the Clinical Director. In addition, the Clinical Director and QA staff will report monthly to the PI committee in regards to the Agency's compliance with this corrective action. F. Date of completion: June 19, 2009	